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MEDICAL HISTORY DOCUMENTATION SYSTEM AND METHOD

ABSTRACT OF THE DISCLOSURE

A medical history documentation system and method for recording information relating to at least one of a designated patient's current medical condition, a physical examination, a diagnosis and a treatment plan is shown. The system includes a recording member having a plurality of discrete recording sections formed thereon programmed for recording information relating to the patient. The encoded indicia is communicated by a first person to a second person during a physical examination of the patient by the first person. An input member is used by the second person for recording medical information in the form of predetermined encoded indicia in applicable discrete recording sections of the recording member. A transcriber having a plurality of report section templates is used. Each report section template corresponds to a discrete recording section. Each of the report section templates comprise a plurality of optional text variable segments each of which are assigned to a selected one of the predetermined encoded indicia. The transcriber is operative to decode each one of the predetermined encoded indicia recorded on the recording member. An imaging device responsive to the transcriber prepares a patient's report specific to the designated patient. A method for using the system is shown.

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